8/2010 **REQUEST FOR HEARING/AGENCY ACTION**

***Mandatory Fields. Please Print Clearly**

This request must be filled out as completely as possible and filed with the Director's Office, Formal Hearings, Division of Medicaid and Health Financing, WITHIN THIRTY (30) DAYS OF THE DATE A DENIAL NOTICE IS ISSUED.

*Person Requesting Hearing: _____*Phone #: _____

*Address: _____ e-mail address: _____

*Name of Client: _____Client I.D.#:_____

Medicaid Provider Name:_____ Provider NPI# _____

*Program (check one): ☐Medicaid Traditional ☐Medicaid Non-Traditional ☐PCN ☐CHIP ☐Other_____

Procedure or Service Code(s): _____ Number of Units Requested: _____
Date(s) of Service: _____Prior Authorization Request? ☐Yes ☐No

*Please explain the reason for requesting a hearing (the relief or action sought):_____

_____

_____

Please list the facts and explanations for this request of relief: _____

_____

CONTINUED BENEFITS*:* Some types of assistance can be continued pending a hearing **if hearing request is made within 10 days of the date of the notice with which you disagree**. If the hearing decision supports the Department's action and you are not successful in any further appeal of that decision, you may have an overpayment if you received continued assistance. You will have to pay back any overpayment.
Do you want your benefits continued? ☐I want my benefits continued. ☐I do not want my benefits continued.

You may represent yourself, have another person represent you, or retain an attorney to represent you. If you will be represented by an attorney, the attorney must file a Notice of Appearance at least ten (10) days before any scheduled hearing or prehearing. *Will you have attorney representation? ☐Yes ☐No

Name of Representative/Attorney: _____

Address: _____ Telephone Number: _____

PLEASE ENCLOSE A COPY OF THE DENIAL NOTICE that caused you to request this hearing, and medical records that support your position. Lack of appropriate and complete medical records will delay your hearing.

_____ _____
Signature of person requesting hearing Date

A copy of this request must be mailed to each person known to have a direct interest in the requested agency action.

Name and address of additional person(s) you would like to be notified of your hearing:

_____ _____

_____ _____

SEND REQUEST TO:

Via U.S. Post Office	**Via UPS or FedEx**
Director's Office/Formal Hearings Division of Medicaid and Health Financing PO Box 143105 Salt Lake City, UT 84114-3105	Director's Office/Formal Hearings Division of Medicaid and Health Financing 288 North 1460 West Salt Lake City, UT 84116-3231

Telephone: 801-538-6576 Fax: 801-536-0143